8. Private duty nursing services. (continued)

3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

4) a contingency plan that accounts for absence of the recipient in a shared care setting due to illness or other circumstances. The private duty nurse will not be paid if the recipient is absent;

5) staffing backup contingencies in the event of employee illness or absence;

6) arrangements for additional assistance to respond to urgent or emergency care needs of recipients.

- The following services are not covered under medical assistance as private duty nursing services:

a) private duty nursing services provided by a licensed registered nurse or licensed practical nurse who is the recipient's spouse, legal guardian, or parent of a minor child or foster care provider of a recipient who is under age 18;

b) private duty nursing services that are the responsibility of the foster care provider;

c) private duty nursing services when the number of foster care residents is greater than four;

d) private duty nursing services when combined with home health services, personal care services, and foster care payments, less the base rate, that exceed the total amount that public funds would pay for the recipient's care in a medical institution (This is a utilization control limitation conducted on a case-by-case basis in order to provide the recipient with the most cost-effective, medically appropriate services.); or

e) private duty nursing services provided to a resident of a hospital, nursing facility, intermediate care facility, or a licensed health care facility.

9. Clinic services.

- A clinic that provides physician services must have at least two physicians on staff. The clinic service must be provided by or under the supervision of a physician who is a provider, except in the case of nurse-midwife services.

- A clinic that provides dental services as defined in item 10 must have at least two dentists on staff. The dental services must be provided by or under the supervision of a dentist who is a provider.

- Clinic services must be provided by a facility that is not part of a hospital or dental care, but is organized and operated to provide medical care to outpatients. This includes an end-stage renal disease clinic certified by Medicare as a renal dialysis facility or unit thereof.

- Coverage of physical therapy, occupational therapy, audiology, and speech language pathology is limited to services within the limitations provided under items 11.a. to 11.c., Physical therapy and related services.

- Providers who administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

10. Dental services.

A. Coverage of dental services is limited to medically necessary services within the scope of practice of a dentist with the following limitations:

Service	Limitation
Oral hygiene instruction	One time only.
Relines or rebase	One every three years.
Topical fluoride treatment	One every six months for a recipient 16 years of age or younger unless prior authorization is obtained.
Full mouth or panoramic x-ray	One every three years, for a recipient eight years of age or older, unless prior authorization is obtained.
Dental examination	One every six months unless an emergency requires medically necessary dental service.
Prophylaxis	One every six months.
Bitewing series	One of no more than four x-rays and no more than six periapical x-rays every 12 months unless a bitewing or periapical x-ray is medically necessary because of an emergency.
Palliative treatment	For an emergency root canal problem.

10. Dental services. (continued.)

Service	Limitation
Sealant application	One application to permanent first and second molars only and one reapplication to permanent first and second molars five years after the first application only for recipients 16 years of age and under.
Removable prostheses (includes instructions in the use and care of the prostheses and any adjustment necessary for proper fit during the first six months)	Requires prior authorization.
Root canal treatment	One root canal therapy per tooth.
Inpatient hospitalization for dental services	Requires prior authorization.
Periodontics	Requires prior authorization.
Orthodontics, except for space maintainers for second deciduous molars	Requires prior authorization.
Surgical services, except emergencies, alveolectomies, and routine tooth extractions	Requires prior authorization.
Removal of impacted teeth, unless it is an emergency	Requires prior authorization.

10. Dental services. (continued.)

Service	Limitation
Fixed cast metal restorations	When cost effective for recipients who cannot use removable dentures because of their medical condition, requires prior authorization. To be considered for prior authorization, the recipient must have less than four upper and four lower back teeth that meet and are in biting function unless the missing teeth are permanent teeth and the recipient has only bicuspid occlusion. A fixed bridge will be considered as a replacement for one or more front teeth.
Orthodontic treatment, except space maintainers	Requires prior authorization.
Services in excess of those listed above	Requires prior authorization.

B. The following dental services are not eligible for payment:

1) Full mouth of panoramic x-rays for a recipient under eight years of age unless prior authorized, or in the case of an emergency;

2) Base or pulp caps, direct or indirect;

3) Local anesthetic that is billed as a separate procedure;

4) Hygiene aids, including toothbrushes;

5) Medication dispensed by a dentist that a recipient is able to obtain from a pharmacy;

6) Acid etch for a restoration that is billed as a separate procedure;

10. Dental services. (continued.)

7) Periapical x-rays, if done at the same time as a panoramic or full mouth x-ray survey unless prior authorization is obtained;

8) Prosthesis cleaning;

9) Unilateral partial prosthesis involving posterior teeth;

10) Replacement of a denture when a reline or rebase would correct the problem;

11) Duplicate x-rays;

12) Crowns and bridges, unless the recipient has a documented medical condition that prohibits the use of a removable prostheses; and

13) Gold restoration or inlay, including cast nonprecious and semiprecious metals.

11. Physical therapy and related services.

See items 11.a. through 11.c.

11.a. Physical therapy services.

Coverage is limited to:

(1) Services prescribed by a physician, physician assistant or nurse practitioner;

(2) Services provided by a physical therapist or a physical therapist assistant who is under the direction of a physical therapist;

(3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician, physician assistant or nurse practitioner at least once every 60 days;

(4) (A) Services that are rehabilitative and therapeutic and are provided to a recipient whose functional status is expected by the physician or nurse practitioner to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; or

(B) Services that are specialized maintenance therapy provided to a recipient who cannot be treated only through rehabilitative nursing services because they have one of the following conditions:

(i) Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care;

(ii) A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance movement patterns, activities of daily living, or positioning necessary for completion of the recipient's activities of daily living;

(iii) An orthopedic condition that may lead to physiological deterioration and require therapy intervention by a physical therapist to maintain strength, joint mobility and cardio-vascular function;

11.a. Physical therapy services. (continued)

(iv) Chronic pain that interferes with functional status and is expected by the physician to respond to therapy;

(v) Skin breakdown that requires a therapy procedure other than a rehabilitative nursing service.

Physical therapist is defined as a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent. Physical therapists must meet state licensure requirements when they are developed.

Physical therapist assistant is defined as one qualified under the rules of the Board of Medical Examiners. These rules define a physical therapist assistant as a skilled technical worker who is a graduate of a physical therapy assistant educational program accredited by the American Physical Therapy Association or a comparable accrediting agency. A physical therapist assistant performs selected physical therapy treatments and related duties as delegated by the physical therapist to assist the physical therapist in patient, client or resident related activities.

Direction is defined as the actions of a physical therapist who instructs the physical therapist assistant in specific duties to be performed, monitors the provision of services as the therapy assistant provides the services, is on premises not less than every sixth treatment session of each recipient when treatment is provided by a physical therapist assistant and meets the other supervisory requirements specified in the rules of the Board of Medical Examiners.

Coverage does *not* include:

(1) Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility;
(2) Ambulation of a recipient who has an established gait pattern.
(3) Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures.
(4) Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide.

11.a. Physical therapy services. (continued)

(5) Bowel and bladder retraining programs.
(6) Arts and crafts activities for the purposes of recreation.
(7) Services that are not documented in the recipient's health care record.
(8) Services that are not designed to improve or maintain the functional status of a recipient with a physical impairment.
(9) Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the recipient's individualized education plan.
(10) A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements.
(11) Evaluations or reevaluations performed by a physical therapist assistant.
(12) Services provided in a nursing facility, ICF/MR or day training and habilitation services centers, if the cost of physical therapy has been included in the facility's per diem.
(13) Services provided by a physical therapist other than the therapist billing for the services, unless the physical therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case the agency, facility or physician must bill for the service.
(14) Services provided by an independently enrolled physical therapist who is not Medicare certified.
(15) Services provided by an independently enrolled physical therapist who does not maintain an office at his or her expense.
(16) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.b. Occupational therapy services.

Coverage is limited to:

(1) Services prescribed by a physician, physician assistant or nurse practitioner;

(2) Services provided by an occupational therapist or an occupational therapy assistant who is under the direction of an occupational therapist;

(3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician, physician assistant or nurse practitioner at least once every 60 days; and

(4) (A) Services that are rehabilitative and therapeutic and are provided to a recipient whose functional status is expected by the physician or nurse practitioner to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; or

(B) Services that are specialized maintenance therapy provided to a recipient who cannot be treated only through rehabilitative nursing services because they have one of the following conditions:

(i) Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care;

(ii) A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance movement patterns, activities of daily living, or positioning necessary for completion of the recipient's activities of daily living;

11.b. Occupational therapy services. (continued)

(iii) An orthopedic condition that may lead to physiological deterioration and require therapy intervention by an occupational therapist to maintain strength, joint mobility and cardiovascular function;

(iv) Chronic pain that interferes with functional status and is expected by the physician to respond to therapy;

(v) Skin breakdown that requires a therapy procedure other than a rehabilitative nursing service.

Occupational therapist is defined as an individual currently registered by the American Occupational Therapy Association as an occupational therapist.

Occupational therapy assistant is defined as an individual holding an associate degree in occupational therapy and who is currently certified by the American Occupational Therapy Certification Board as an occupational therapy assistant.

Direction is defined as the actions of an occupational therapist who instructs the occupational therapy assistant in specific duties to be performed, monitors the provision of services as the therapy assistant provides the service, and is on premises not less than every sixth treatment session of each recipient when treatment is provided by an occupational therapy assistant.

Coverage does *not* include:

(1) Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility.

(2) Ambulation of a recipient who has an established gait pattern.

(3) Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures.

11.b. Occupational therapy services. (continued)

(4) Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide.

(5) Bowel and bladder retraining programs.

(6) Arts and crafts activities for the purpose of recreation.

(7) Services that are not documented in the recipient's health care record.

(8) Services that are not designed to improve or maintain the functional status of a recipient with a physical impairment.

(9) Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the recipient's individualized education plan.

(10) A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements.

(11) Evaluations or reevaluations performed by an occupational therapy assistant.

(12) Services provided in a nursing facility, ICF/MR or day training and habilitation services center, if the cost of occupational therapy has been included in the facility's per diem.

(13) Services provided by an occupational therapist other than the therapist billing for the service, unless the occupational therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.

(14) Services provided by an independently enrolled occupational therapist who is not Medicare certified.

(15) Services provided by an independently enrolled occupational therapist who does not maintain an office at his or her own expense.

11.b. Occupational therapy services. (continued)

(16) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).

Coverage of **speech and language therapy services** is limited to:

(1) Services provided upon written referral by a physician, physician assistant or nurse practitioner or in the case of a resident of a long-term care facility on the written order of a physician as required by 42 CFR §483.45.
(2) Services provided by a speech language pathologist or a person completing the clinical fellowship year required for certification as a speech-language pathologist under the supervision of a speech-language pathologist.
(3) Services provided to a recipient whose functional status is expected by the physician or nurse practitioner to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period.
(4) For long term care recipients, services for which there is a statement in the clinical record every 30 days that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.
(5) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician, physician assistant or nurse practitioner at least once every 60 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.

Speech-language pathologist is defined as a person who has a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association and meets the state licensure and registration requirements for the services the person provides.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Coverage of **speech-language therapy services** does *not* include:

(1) Services that are not documented in the recipient's health care record.
(2) Services by more than one provider of the same type for the same diagnosis unless the service is provided by a school district as specified in the recipient's individualized education plan.
(3) Services that are denied Medicare payment because of the provider's failure to comply with Medicare requirements.
(4) Services that are provided without written referral.
(5) Services not medically necessary.
(6) Services that are not part of the recipient's plan of care.
(7) Services provided in a nursing facility, ICF/MR or day training and habilitation services center if the cost of speech-language pathology has been included in the facility's per diem.
(8) Services provided by a speech-language pathologist other than the pathologist billing for the service, or a person completing the clinical fellowship year under the supervision of the pathologist, unless the pathologist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.
(9) Services provided by an independently enrolled speech language pathologist who does not maintain an office at his or her own expense.

Coverage of **hearing (audiology) therapy services** is limited to:

(1) Services provided upon written referral by a physician, physician assistant or nurse practitioner.
(2) Services provided by an independently enrolled audiologist who maintains an office at their own expense or an audiologist who is employed by and providing audiology services in a hospital, rehabilitation agency, home health agency, or clinic.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

(3) Services provided to a recipient who is expected to progress toward or achieve the objective specified in their plan of care within a 60-day period.
(4) Services provided under a written treatment plan which is reviewed at least once every 60 days, with certification and recertification by the ordering physician or physician assistant. If the service is provided to a Medicare beneficiary and covered by Medicare, the physician or physician delegate must review the plan of care and visit the patient at intervals required by Medicare rather than at intervals required by MA.
(5) For long term care recipients, services for which there is a statement in the clinical record every 30 days by the audiologist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. (This statement is not required for an initial evaluation).
(6) Services provided in the independent audiologist's own office, recipient's home, nursing facility, ICF/MR, or day training and habilitation services site.

Audiologist is defined as an individual who has a certificate of clinical competence from the American Speech-Language-Hearing Association.

Coverage of **hearing (audiology) therapy services** does *not* include:

(1) Services that are not documented in the recipient's clinical record, even if the services were authorized by a physician.
(2) Training or consultation provided by an audiologist to an agency, facility, or other institution.
(3) Services provided by an audiologist other than the audiologist billing for the services, or a person completing the clinical fellowship year under the supervision of the audiologist, unless the audiologist provided the services in a hospital, rehabilitation agency, home health agency, or clinic, or as an employee of a physician or long-term care facility; in which case the contracting or employing facility,

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

agency, or person must bill for the services.

Hearing aid services: After a physician rules out medical and surgical contraindications, the physician refers the recipient for an audiologic evaluation. An audiologist or otolaryngologist provides audiologic testing, and if a hearing aid is indicated, prescribes a specific hearing aid offered under the hearing aid volume purchase contract or refers the recipient to a hearing aid services provider.

Payment is made to hearing aid services providers for hearing aids, dispensing fees, hearing aid repairs, accessories, ear molds when not provided with the hearing aid and batteries.

Coverage of **hearing aids** is limited to:

(1) One monaural or one set of binaural hearing aids within a period of five years unless prior authorized. A hearing aid will not be replaced when the recipient has received a replacement hearing aid twice within the five year period previous to the date of the request.
(2) Non-contract hearing aids require prior authorization.

Coverage of **hearing aids** does *not* include:

(1) Replacement batteries provided on a scheduled basis regardless of their actual need.
(2) Services specified as part of the contract price when billed on a separate claim for payment. This includes any charges for repair of hearing aids under warranty.
(3) Routine screening of individuals or groups for identification of hearing problems.
(4) Separate reimbursement for postage, handling, taxes, mileage, or pick-up and delivery.
(5) Nonelectronic hearing aids, telephone amplifiers, vibrating molds, dry aid kits, and battery chargers.
(6) Maintenance, cleaning, and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian or attending physician.
(7) Loaner hearing aid charges.
(8) Canal type hearing aids.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

(9) A noncontract hearing aid that is obtained without prior authorization.
(10) Services included in the dispensing fee when billed on a separate claim for payment.
(11) Hearing aid services to a resident of a long-term care facility if the services did not result from a request by the resident, a referral by a registered nurse or licensed practical nurse who is employed by the long-term care facility, or a referral by the resident's family, guardian or attending physician.
(12) Hearing aid services prescribed or ordered by a physician if the physician or entity commits a felony listed in United States Code, title 42, section 1320a-7b, subject to the "safe harbor" exceptions listed in 42 CFR 1001.952.
(13) Replacement of a lost, stolen or damaged hearing aid if MA has provided three hearing aids in the five years prior to the date of the request for a replacement.

Augmentative and alternative communication devices are defined as devices dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a recipient with severe expressive communication disorders. Examples include: communication picture books, communication charts and boards, and mechanical or electronic dedicated devices. Prior authorization must be obtained for all augmentative communication devices.

Coverage of **augmentative and alternative communication devices** is limited to:

(1) Evaluation for use of augmentative and alternative communication devices to supplement oral speech.
(2) Speech pathologists may only provide modification and programming of augmentative and alternative communication devices.
(3) Construction, programming or adaptation of augmentative and alternative communication devices.

Augmentative and alternative communication devices are not covered ~~if~~ facilitated communication is required.

12. Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

See items 12.a. through 12.d.

12.a. Prescribed drugs.

The following providers are eligible for payment for dispensing prescribed drugs:

(1) A pharmacy that is licensed by the Minnesota Board of Pharmacy.
(2) An out of state pharmacy that complies with the licensing and certification requirements of the state in which it is located.
(3) A physician located in a local trade area where there is no Medicaid enrolled pharmacy. To be eligible for payment, the physician shall personally dispense the prescribed drug according to applicable Minnesota Statutes and shall adhere to the labeling requirements of the Minnesota Board of Pharmacy.
(4) A physician or nurse practitioner employed by or under contract with a community health board, for the purposes of communicable disease control.

The following limitations apply to pharmacy services:

(1) With the exception noted below, the prescribed drug must be a drug or compounded prescription that is made by a manufacturer that has a rebate with the Health Care Financing Administration (HCFA) and included in the Minnesota Department of Human Services drug formulary. The formulary is established in accordance with §1927 of the Social Security Act. See Drug Formulary.

A prescribed drug is covered if it has Investigational New Drug (IND) status with an IND number by the United States Food and Drug Administration (FDA), even though the manufacturer does not have a rebate with HCFA. When the prescribed drug receives FDA approval, the manufacturer must have a rebate agreement for the drug in order for the drug to be covered.

(2) A prescribed drug must be dispensed in the quantity specified on the prescription unless the pharmacy is using unit dose dispensing or the specified quantity is not available in the pharmacy when the prescription is dispensed. Only one dispensing fee is allowed for dispensing the quantity specified on the prescription.

12.a. Prescribed drugs. (continued)

(3) The dispensed quantity of a prescribed drug must not exceed a three-month supply.

(4) An initial or refill prescription for a maintenance drug shall be dispensed in not less than a 30-day supply unless the pharmacy is using unit dose dispensing. No additional dispensing fee shall be paid until that quantity is used by the recipient.

(5) Except as provided in item (6), coverage of the dispensing fee for a particular pharmacy or dispensing physician for a maintenance drug for a recipient is limited to one fee per 30-day supply.

(6) More than one dispensing fee per calendar month for a maintenance drug for a recipient is allowed if:

(a) the record kept by the pharmacist or dispensing physician documents that there is a significant chance of overdosage by the recipient if a larger quantity of drug is dispensed, and if the pharmacist or dispensing physician writes a statement of this reason on the prescription; or

(b) the drug is clozapine.

(7) A refill of a prescription must be authorized by the practitioner. Refilled prescriptions must be documented in the prescription file, initialed by the pharmacist who refills the prescription, and approved by the practitioner as consistent with accepted pharmacy practice under Minnesota Statutes.

(8) Generic drugs must be dispensed to recipients if:

(a) the generically equivalent drug is approved and is determined as therapeutically equivalent by the FDA;